Wisconsin Chronic Disease Program Companion Document to HIPAA Implementation Guide: 837 Institutional

Department of Health & Family Services
Division of Health Care Financing
PHC 1146 (01/04)

Companion Document Audience

Companion documents are intended for information technology and/or systems staff who will be coding billing systems or software for compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Purpose of Companion Documents

The information contained in this companion document applies to Wisconsin Chronic Disease Program (WCDP).

The companion documents are designed to be used with HIPAA Implementation Guides. Companion documents provide WCDP-specific information that details the way to create HIPAA transactions for WCDP and explains how WCDP creates HIPAA transactions. Companion documents clarify the HIPAA-designated standards usage but are not intended to supercede them. The purpose of companion documents is to provide trading partners with a guide to communicate the WCDP-specific information required to successfully exchange transactions electronically with WCDP.

WCDP will accept and process 837 Institutional and Professional as well as NCPDP v5.1 - compliant transactions. However, a compliant transaction that doesn't contain WCDP-specific information, though processed, may be denied for payment. For example, a compliant 837 Institutional claim created without a valid WCDP covered diagnosis code will be processed by WCDP, but will be denied payment. WCDP will not accept 837 Dental claims. Please submit dental claims on paper.

Companion documents highlight the data elements significant for WCDP. Please refer to the companion document first if there is a question about how WCDP processes a HIPAA transaction.

If your facility will be using the PES software to submit claims to Wisconsin Medicaid, please be aware this claim submission software is not compatible with the WCDP system. The PES software provided by Wisconsin Medicaid does not have the required fields needed to submit claims to WCDP.

For further information, contact the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department at (608) 221-9036.

X12 837 Health Care Claim: Institutional

Loop	Element	Name	Instructions
	ISA	Interchange control header	The ISA is a fixed-length record with fixed-length elements. *Note:* Deviating from the standard's ISA element sizes will cause the interchange to be rejected.
	ISA05	Interchange ID (sender) qualifier	Enter the value "ZZ", mutually defined.
	ISA06	Interchange sender ID	Enter the eight-digit numeric vendor number assigned by Wisconsin Medicaid.
	ISA07	Interchange ID (receiver) qualifier	Enter the value "ZZ", mutually defined.
	ISA08	Interchange receiver ID	Enter "WISC_DHFS".
	GS02	Application sender's code	Enter the same value as ISA06, the eight-digit numeric vendor number assigned by Wisconsin Medicaid.
	GS03	Application receiver's code	Enter "WISC_WCDP" for Wisconsin Chronic Disease Program.
	GS08	Version / release / industry identifier code	Enter the value "004010X0**96**A1", the HIPAA mandated implementation guide release for this transaction. *Note:* This code represents the HIPAA implementation guide with the most recent addenda changes. Using an earlier guide, without the most recent addenda changes, does not comply with the HIPAA rule and will cause the transaction to be rejected.

Loop	Element	Name	Instructions
	BHT03	Reference identification	Make this identifier unique to a single transaction (ST to SE envelope). Repeating a value will cause the transaction to be rejected. WCDP recommends using a value with an easily identifiable pattern to aid research (e.g., "ANY_GROUP_PRACTICE_20031016" or "ANY GROUP PRACTICE #00001").
	REF02	Reference identification	Enter the value "004010X096A1" to indicate institutional claim. *Note:* This version includes the addenda.
1000A	NM109	Submitter primary identification number	Enter the same value as ISA06, the eight-digit numeric vendor number assigned by Wisconsin Medicaid. Note: A new vendor number will be issued for submitting HIPAA transactions. This number will replace the submitter's current vendor number.
1000B	NM101	Entity identifier code	Enter the value "40" for receiver.
1000B	NM102	Entity type qualifier	Enter the value "2" for non-person entity.
1000B	NM103	Name last or organization name	Enter "WCDP" to indicate the claims are being sent to WCDP.
1000B	NM108	Identification code qualifier	Enter the value "46" for electronic transmitter identification number.
1000B	NM109	Receiver primary identification number	Enter the same value as GS03, "WISC_WCDP" for WCDP.
2000A	PRV01	Provider code	Enter "BI" to indicate the service facility provider is the same entity as the billing provider or "PT" to indicate the service facility provider is the same entity as the pay-to provider.

Loop	Element	Name	Instructions
2010AA	REF	Billing provider secondary ID	Include this segment if the provider in loop 2010AA is the provider certified by Wisconsin Medicaid to submit claims. *Note:* WCDP requires all claims be submitted with the Wisconsin Medicaid billing provider number.
2010AA	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid provider number.
2010AA	REF02	Billing provider additional identifier	Enter the eight-digit Wisconsin Medicaid billing provider number.
2010AB	NM1	Pay-to provider name	*Note:* The information in this segment will not be used to determine where to send the provider Remittance and Status Report (R/S). The R/S Report will be sent to the entity established during the provider certification process.
2010BA	NM1	Subscriber name	Enter information about the subscriber/recipient in this loop.
2010BA	NM102	Entity type qualifier	Enter the value "1" to indicate the subscriber is a person.
2010BA	NM103	Subscriber last name	Enter the recipient's last name. *Note:* Use the WCDP identification card to obtain the correct spelling of the recipient's last name.
2010BA	NM104	Subscriber first name	Enter the recipient's first name. *Note:* Use the WCDP identification card to obtain the correct spelling of the recipient's first name.
2010BA	NM108	Identification code qualifier	Enter the value "MI" for the member identification number.

Loop	Element	Name	Instructions
2010BA	NM109	Subscriber primary identifier	Enter the recipient's 10-digit WCDP identification number. *Note:* The first digit of the WCDP ID must be either a C, K or H. Use the WCDP identification card to obtain the correct identification number.
2300	CLM01	Patient account number	*Note:* WCDP will process patient account numbers up to 20 characters in length.
2300	CLM02	Total claim charge amount	Enter the total billed amount for the entire claim. *Note:* WCDP will process claims submitted with a negative total billed amount as if the provider submitted a zero total billed amount.
2300	CLM05-1	Facility code value	Enter the first two digits of the type of bill. See the National Uniform Billing Committee (NUBC) manual or Web site *www.nubc.org* for appropriate value selections.
2300	CLM05-3	Claim frequency code	The third digit of the type of bill, as defined by the NUBC, is the frequency. Use the claim frequency code to indicate the claim is being submitted for the first time. WCDP will not be accepting electronic adjustments. • WCDP will treat all claim frequency codes as if submitted as a "1". • All requests for adjustments (replacement/void of a previously adjudicated claim or paid claim) must be submitted on paper with supporting documentation using the WCDP claim adjustment form located in the WCDP Provider Handbook.
2300	DTP01	Date time qualifier	Enter the value "434" for statement dates.
2300	DTP02	Date time period format qualifier	Enter the value "D8" if all the services being billed on the claim were performed on the same date or "RD8" if all the services being billed on the claim were not performed on the same date.

Loop	Element	Name	Instructions
2300	DTP03	Statement from and to date	If "D8" was used in the previous element, enter the date on which all the services were performed. If "RD8" was used in the previous element, enter the date period that covers all the services on the claim.
2300	DTP01	Date time qualifier	Enter the value "435" for admission date.
2300	DTP02	Date time period format qualifier	Enter the value "DT" to indicate the date is displayed in CCYYMMDDHHMM.
2300	DTP03	Admission date and hour	Enter the date the patient was admitted for care.
2300	CL101	Admission type code	Enter the type of admission code. *Note:* Consult the NUBC manual for appropriate value selections.
2300	CL102	Admission source code	Enter the source of admission code. *Note:* Consult the NUBC manual for appropriate value selections.
2300	CL103	Patient status code	Enter the patient status code. *Note:* Consult the NUBC manual for appropriate value selections.
2300	PWK	Claim supplemental information	*Note:* WCDP will review the 275 Additional Information to Support a Health Care Claim or Enrollment transaction once the Federal Rule is finalized. In the meantime, submit all claims requiring attachments on paper.
2300	REF	Medical record number	Enter the medical record number in this segment.
2300	REF01	Reference identification qualifier	Enter the value "EA" for MRN.
2300	REF02	Medical record number	Enter the MRN.
2300	HCP01	Indicator	Enter the value “10” for Other Pricing. All WCDP Institutional Claims must provide the Medicare Allowed amount.

Loop	Element	Name	Instructions
2300	HCP02	Medicare Allowed Amount	Enter the total Medicare allowed amount for the claim in this segment.
2300	HI	Health care diagnosis code	Enter the principal diagnosis, admitting diagnosis, and E-code in this segment.
2300	HI01-1	Code list qualifier Code	Enter the value "BK" for Principal Diagnosis.
2300	HI01-2	Industry code	Enter the principal diagnosis code. *Note:* WCDP will use up to five diagnosis codes to process a claim, however a WCDP covered diagnosis code must be entered as the primary diagnosis code for the claim to pay successfully. The principal diagnosis code is included in the five.
2300	HI02-1	Code list qualifier code	Enter the value "BJ" for admitting diagnosis.
2300	HI02-2	Industry code	Enter the admitting diagnosis code.
2300	HI03-1	Code list qualifier Code	Enter the value "BN" for United States Department of Health and Human Services, Office of Vital Statistics E-code.
2300	HI03-2	Industry code	Enter the value "E".
2300	HI	Other diagnosis information	Enter additional diagnosis codes in this segment, if necessary. *Note:* WCDP will use up to five diagnosis codes in this segment, including the principal diagnosis, to process a claim.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1	Code list qualifier code	Enter the value "BF" for each additional diagnosis code.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2	Other diagnosis	Enter additional diagnosis codes in order of importance.

Loop	Element	Name	Instructions
2300	HI	Principal procedure information	Enter principal procedure information in this segment.
2300	HI01-1	Code list qualifier code	Enter the value "BR" for the *International Classification of Diseases – Ninth Edition – Clinical Modification* (ICD-9-CM) principal procedure diagnosis code.
2300	HI01-2	Principal procedure code	Enter the principal procedure code. *Note:* WCDP will use up to six procedure codes to process the claim.
2300	HI01-3	Date time period format qualifier	Enter the value "D8" for format CCYYMMDD.
2300	HI01-4	Date time period	Enter the date corresponding to the principal procedure code.
2300	HI	Other procedure information	Enter additional procedure information in this segment. *Note:* WCDP will use up to six procedure codes including the principal procedure to process the claim.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1	Code list qualifier code	Enter the value "BQ" for the *International Classification of Diseases – Ninth Edition – Clinical Modification* (ICD-9-CM) principal procedure diagnosis code.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2	Procedure code	Enter additional procedure codes.
2300	HI01-3 HI02-3 HI03-3 HI04-3 HI05-3	Date time period format qualifier	Enter the value "D8" for format CCYYMMDD.
2300	HI01-4 HI02-4 HI03-4	Procedure date	Enter the date corresponding to the additional procedure code.

Loop	Element	Name	Instructions
	HI04-4 HI05-4		
2300	HI	Value information	Enter value code information in this segment.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1	Code list qualifier code	Enter the value "BE" for value code.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2	Value code	Enter the value code. *Note:* WCDP will use up to five value codes to process the claim. For the claim to process correctly A1/A2 should be listed in the first 5 value codes
2300	HI01-5 HI02-5 HI03-5 HI04-5 HI05-5	Value code associated amount	Enter the dollar amount corresponding to the value code.
2300	QTY	Claim quantity	This segment repeats multiple times. Use one iteration for covered days and a second iteration for non-covered days. *Note:* This segment is required for all inpatient claims.
2300	QTY01	Quantity qualifier	Enter the value “CA” for covered days or "NA" for non-covered days.
2300	QTY02	Claim days count	Enter the number of covered or non-covered days. *Note:* This element is required on all inpatient claims.

Loop	Element	Name	Instructions
2310A	NM101	Entity identifier code	Enter the value "71" for attending physician.
2310A	NM103	Attending physician last name	Enter the attending provider's last name.
2310A	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310A	REF02	Attending physician secondary identifier	Enter the eight-digit provider number assigned to the attending physician by Wisconsin Medicaid.
2310B	NM101	Entity identifier code	Enter the value "72" for operating physician.
2310B	NM103	Operating physician last name	Enter the operating physician's last name.
2310B	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310B	REF02	Operating physician secondary identifier	Enter the eight-digit provider number assigned to the operating physician by Wisconsin Medicaid.
2310E	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310E	REF02	Facility secondary identifier	Enter the eight-digit provider number assigned to the facility by Wisconsin Medicaid.

Loop	Element	Name	Instructions

2320	SBR	Other subscriber information	Include this loop when any of the following occur:
			• The claim will be processed by multiple payers.
			• The recipient has commercial health insurance or commercial HMO coverage, but the claim was not billed to the other payer for reasons including, but not limited to:
			  • The recipient denied coverage or will not cooperate.
			  • The provider knows the service in question is not covered by the carrier.
			  • The recipient's commercial health insurance failed to respond to initial and follow-up claims.
			  • Benefits are not assignable or cannot get assignment.
			  • Benefits are exhausted.
			• The claim was not sent to Medicare Part A, the billing provider identified is certified for Medicare Part A, the recipient is eligible for Medicare Part A, and the service is usually covered by Medicare Part A but not in this circumstance.
			• The claim was not sent to Medicare Part B, the billing provider identified is certified for Medicare Part B, the recipient is eligible for Medicare Part B, and the service is usually covered by Medicare Part B but not in this circumstance.

Loop	Element	Name	Instructions
2320	SBR09	Claim filing indicator code	Enter the type of payer. WCDP uses this information when evaluating other insurance information. If this claim was not submitted to a commercial health insurance plan or commercial HMO plan based on the reasons listed for the SBR segment in loop 2320, enter one of the following values: • "12" for Preferred Provider Organization (PPO). • "13" for Point of Service (POS). • "14" for Exclusive Provider Organization (EPO). • "BL" for Blue Cross/Blue Shield. • "CH" for Champus. • "CI" for Commercial Insurance Co. • "DS" for Disability. • "HM" for HMO. • "VA" for Veteran Administration Plan. If this claim was not submitted to Medicare based on the reasons listed for the SBR segment in loop 2320, enter one of the following values: • “MA" for Medicare Part A. • "MB" for Medicare Part B. • "16" for HMO Medicare risk.
2320	CAS	Claim level adjustment	Include this segment when another payer has made payment at the claim level. If the other payer returned an 835 HealthCare Claim Payment/Advice, the CAS segment from the 835 should be copied to this CAS. *Note:* WCDP will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code” submitted prior to HIPAA. If this iteration of loop 2320 contains information from a Medicare payer, WCDP will also look for Medicare's coinsurance, copayment and deductible in this segment.
2320	AMT	Payer prior payment	This segment contains the amount paid on this claim by the payer within this 2320 loop.

Loop	Element	Name	Instructions
2320	AMT01	Amount qualifier code	Enter the value "C4" for prior payment-actual.
2320	AMT02	Other payer patient paid amount	Enter the amount paid on this claim by the payer within this 2320 loop.
2320	AMT01	Amount qualifier code	Enter the value "B6" for allowed amount.
2320	AMT02	Allowed amount	Enter the other payer's allowed amount. *Note:* If this claim was not submitted to another payer, zero must be indicated as the allowed amount.
2320	AMT01	Amount qualifier code	Enter the value "A8" for non-covered charges –- actual.
2320	AMT02	Non-covered charge amount	Enter the non-covered charges.
2320	MIA	Medicare inpatient adjudication information	Include this segment when it was returned in the 835 HealthCare Claim Payment/Advice from a previous payer or if this iteration of 2320 is being used to indicate that an inpatient hospital claim was not submitted to another payer based on the notes in the SBR segment of loop 2320 of this document.
2320	MIA05	Remark code	If the claim was not submitted to another payer, enter "MA07" in this element.
2320	MOA	Medicare outpatient adjudication information	Include this segment when it was returned in the 835 HealthCare Claim Payment/Advice from a previous payer or if this iteration of 2320 is being used to indicate an outpatient claim was not submitted to another payer based on the notes in the SBR segment of loop 2320 of this document.
2320	MOA03	Remark Code	If the claim was not submitted to another payer, enter "MA07" in this element.
2330B	NM109	Other payer primary identifier	Enter the other payer's identifier. *Note:* WCDP will use this number in combination with loop 2430 to calculate other insurance and Medicare payments.

Loop	Element	Name	Instructions
2330B	DTP03	Adjudication or payment date	Enter Medicare's claim paid date.
2400	SV201	Service line revenue code	Enter the revenue code for the services performed. *Note:* Revenue codes are four digits.
2400	SV202	Composite medical procedure identifier	Enter a Healthcare Common Procedure Coding System (HCPCS) code, when necessary to supplement the revenue code.
2400	SV202-1	Product or service ID qualifier	Enter the value "HC" for HCPCS code. *Note*: Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under qualifier HC.
2400	SV202-2	Procedure code	Enter the HCPCS/CPT code for the services performed.
2400	SV203	Line item charge amount	Enter the billed amount for each service line. *Note:* WCDP will process claims submitted with a negative service line billed amount as if the provider submitted a zero service line billed amount.
2400	SV204	Unit or basis for measurement	Enter the value "DA" for days or "UN" for units.
2400	SV205	Service unit count	Enter the number of days or units for the services provided.
2400	SV207	Line item denied charge or non-covered charge amount	Enter the service line non-covered amount.
2400	DTP01	Date time qualifier	Enter the value "472" for service dates.
2400	DTP02	Date time period format qualifier	Enter the value "D8" to indicate a single date of service or "RD8" to indicate a range of service dates for the service line.

Loop	Element	Name	Instructions
2400	DTP03	Service date	Enter the date(s) the procedure was performed. *Note*: WCDP requires service line dates on all outpatient claims.
2420A	NM101	Entity identifier code	Enter the value "71" for attending physician.
2420A	NM103	Attending physician last name	Enter the attending physician's last name.
2420A	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2420A	REF02	Attending physician secondary identifier	Enter the eight-digit provider number assigned to the attending physician by Wisconsin Medicaid.
2420B	NM101	Entity identifier code	Enter the value "72" for operating physician.
2420B	NM103	Operating physician last name	Enter the operating physician's last name.
2420B	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2420B	REF02	Operating physician secondary identifier	Enter the eight-digit provider number assigned to the operating physician by Wisconsin Medicaid.
2430	SVD01	Payer identifier	Enter the payer identifier when another payer has paid on the service line.
2430	SVD02	Service line paid amount	Enter the amount the other payer paid on the service line.

Loop	Element	Name	Instructions
2430	CAS	Service line adjustment	Include this segment when another payer has made payment at the service line. If the other payer returned an 835 remittance with a service line CAS, the CAS segment from the 835 should be copied to this CAS. *Note:* WCDP will use the information in the CAS segment in place of the information submitted prior to HIPAA that is referred to as the "other insurance indicator" and "Medicare disclaimer code". If this iteration of loop 2430 contains information from a Medicare payer, WCDP will also look for Medicare's coinsurance, copayment and deductible.
2430	DTP	Service line adjudication date	Include this segment when another payer has made payment at the service line of this claim.
2430	DTP01	Date/time qualifier	Enter the value "573" for the claim paid date.
2430	DTP02	Date time period format qualifier	Enter the value "D8" to indicate format CCYYMMDD.
2430	DTP03	Service adjudication or payment Date	Enter the date the other payer paid the claim.